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2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A.2 does not apply to a hospital:

   a. at which the inpatients are predominantly individuals under 18 years of age; or

   b. which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment Adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 8% shall receive a disproportionate share payment adjustment.

2. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8%, times eleven, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8%, times (ii) the lower of the prospective operating cost rate or ceiling.

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3. For hospitals which do not qualify under the 8% inpatient utilization rate, but do qualify under the low-income patient utilization rate exceeding 25% in A(1) above, the disproportionate share payment adjustment for Type One hospitals shall be equal to the product of (i) the hospital's low-income utilization in excess of 25%, times eleven, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's low-income utilization in excess of 25%, times (ii) the lower of the prospective operating cost rate or ceiling.

4. OBRA 1993 §13621 Disproportionate Share Adjustments (DSA). Definitions. The following words and terms shall have the following meaning unless the context clearly indicates otherwise.

"High disproportionate share hospital" is one whose Medicaid inpatient utilization rate is at least one standard deviation above the mean inpatient utilization rate in the state or which has the largest number of Medicaid days of any hospital in the Commonwealth for the previous State fiscal year.

"Medicaid losses" means Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year.

"Uninsured losses" means costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

"Private hospital" means a hospital which is not owned or operated by a state or an instrumentality or unit of government within a state.

"Public hospital" means a hospital which is owned or operated by a state or an instrumentality or unit of government within a state.

a. Limit on amount of payment. No payments made under items 1 or 2 above shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 §13621. A payment adjustment during a fiscal year shall not exceed the sum of "Medicaid losses" and "uninsured losses".

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b. During state fiscal year 1995, the limit in this section shall apply only to public hospitals. During this year a high disproportionate share hospital shall be allowed a limit that is 200% of the limit described above which the Governor certifies to the Secretary of the U. S. Department of Health and Human Services that such amount (the amount by which the hospital's payment exceeds the limit described above) shall be used for health services during the year.

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(8) Outlier adjustments.

a. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

b. DMAS shall pay to disproportionate share hospitals (as defined in V.(7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

c. The outlier adjustment calculation.

(1) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(2) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. Any hospital which qualifies for the extensive neonatal care provision (as governed by V.(6), above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in (8) a or b above.

(3) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in (8) c (ii) above.

(4) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital. Pursuant to §1 of Supplement 1 to Attachment 3.1 A & B, there is no limit on length of time for medically necessary stays for individuals under

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six years of age. This section provides that consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under twenty-one (21) years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one (21) days per admission when such services are rendered for the purpose of diagnosis and treament of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

V. The reimbursement system for hospitals includes the following components (continued):

(9) All-inclusive rate for one-day maternity and newborn services.

a. Hospitals may voluntarily participate in a program (the "Home Tomorrow" program) wherein women who have uncomplicated vaginal deliveries may be discharged from the hospital within 24 hours of such deliveries. If providers choose to participate and the patients are determined to be medically appropriate to participate, coverage is provided for routine inpatient services plus a comprehensive home health visit, including a maternal assessment, a newborn assessment, and a home assessment. Reimbursement for the total package of inpatient and outpatient services will be a fixed per case rate. The Home Tomorrow package of services includes one day of inpatient services and one comprehensive home visit provided within 48 hours of discharge. Cases with longer lengths of stay or where a home visit does not occur within 48 hours of discharge shall not be reimbursed under the Home Tomorrow program. These cases will be reimbursed at the normal per diem reimbursement rate.

b. The Home Tomorrow total fixed per case rates in effect from October 16, 1995 through June 30, 1996, shall be:

Northern Virginia	$1,200
Rest of State	$1,100
State Teaching Hospitals	$1,700

These amounts shall be considered to constitute reimbursement both for the services provided (both operating and fixed costs) and for disproportionate share hospital (DSH) payments associated with those services, if applicable.

c. These per case rates will be updated at the beginning of each state fiscal year using the same inflation factor used for hospitals with fiscal years ending at that time. (Refer to V(2) above)

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VI. In accordance with Title 42 §§447.250 through 447.272 of the Code of Federal Regulations which implements §1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of charges in financial position, and footnotes to the financial statements;
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Home office cost report, if applicable; and
6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

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VI. Cost Report Requirements (continued)

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of Assets

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A. and B. above.

VIII. Refund of overpayments

A. Lump sum payment. When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

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B. Offset. If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

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E. Interest charge on extended repayment. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding section I, II, III, IV, V, VI, VII, VIII and excluding V.(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

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X. Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. State-Owned University Teaching Hospitals.

A. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating cost shall be established for state-owned university teaching hospitals.

B. Effective July 1, 1994, the separate group ceiling for allowable operating costs for state-owned university teaching hospitals shall be calculated using cost report and other applicable data pertaining to facility fiscal year ending June 30, 1993.

XII. Non-enrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the lesser of:

1) the DMAS average reimbursable inpatient cost-to-charge ratio, updated anually on September 30 of each year based on the most recent settled cost report, for enrolled hospitals less five percent. (The five percent is for the cost of additional manual processing of the claims.)

2) the DMAS average per diem, updated annually on September 30 of each year based on the most recent settled cost report, of enrolled hospitals excluding the state-owned teaching hospitals and disproportionate share adjustments.

B. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within twelve months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (V.C.1) above). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).